

GPs' strategies in intercultural clinical encounters

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Background. In North America and Europe, patients and physicians are increasingly likely to come from non-Western cultural backgrounds. The expectations of these patients may not match those of physicians.

Objective. To identify strategies used by GPs with patients from cultures other than their own.

Methods. We conducted a qualitative inductive study based on 25 semi-structured interviews with family physicians practising in Montreal, Canada. We elicited physicians' strategies when dealing with patients from a cultural background different from their own. We began by asking physicians to describe an encounter they found difficult and one they found easy.

Results. Physicians reported three types of strategies: (i) insistence on *patient adaptation* to local beliefs and behaviours; (ii) *physician adaptation* to what he or she assumed patients wanted; and (iii) *negotiation* of a mutually acceptable plan. Individual physicians did not adopt the same strategy in all situations. Their choice of strategy depended on the topic. When dealing with issues they felt deeply about, such as the autonomy of women, many physicians insisted on patient adaptation. Physicians used a patient-centred model of care, but had no framework to elicit information about patients' culture.

Conclusions. A patient-centred model of care enables physicians to consult effectively despite a wide range of cultural differences between themselves and their patients. However, their lack of a conceptual framework for addressing cultural difference prevents systematic data collection and consideration of challenges to respect for individual autonomy. Physician training should include the provision of an explicit conceptual framework for approaching patients from a different culture.

Keywords. Cultural diversity, ethnicity, migration and immigration, physician–patient relations.

Introduction

Changing patterns of immigration to North America and Europe have changed the context in which medicine is practised. Patients and physicians are increasingly likely to come from non-Western cultural backgrounds.¹ Physicians worldwide share a Western biomedical culture although few physicians recognize it as a distinct culture.^{2,3} The challenge for physicians is to deliver quality health care to patients whose symptom presentations, and health beliefs and practices may differ from implicit norms.⁴

Recent literature offers guidelines for culturally competent care based on theory-based models of

cultural competence.^{4–9} However, few studies have examined how primary care practitioners actually address issues of cultural diversity in their practice.^{10–12} The present study elicited empiric data on the practices of family physicians with varying degrees of experience in intercultural care in particular clinical encounters.

Background

Changing patterns of immigration to Western countries confront physicians with patients from a great diversity of cultural backgrounds.¹ In Canada in 2001, 18.4% of the total population was foreign born, the

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highest level in 70 years. Early in the 20th century, most immigrants to North America came from Europe, whereas in the last decade, 58% have come from Asia, 11% from the Caribbean, Central and South American, 8% from Africa and only 19% from Europe. In 2005, 22% of physicians practising in Canada graduated from medical school outside of Canada.¹³ The challenge for primary care givers, as for other clinicians, is to continue delivering quality health care despite the wide variation in illness experience and clinical presentation, and to negotiate effective treatment in situations of potentially conflicting health beliefs and practices.

Recent medical literature offers guidelines for culturally competent care and pragmatic advice from individual clinicians^{14–17} These guidelines emphasize the importance of becoming aware of one's own biases, values and ethnocultural background, as well as the implicit assumptions of the 'subculture' of Western medicine. Knowledge of the patient's culture of origin is regarded as helpful, but physicians are warned of the risk of stereotyping and oversimplification. Most authors draw attention to cultural differences in styles of communication and to the role and importance of family and community. Various ways of eliciting information from patients about their health beliefs and the meanings they give to symptoms and illness are recommended, with most models building on Kleinman's explanatory model approach.¹⁸

Nurses, beginning with Leininger, have developed models of cultural competence.^{19–22} These are theoretical models based on theory and research in a wide range of social sciences. The theories discuss the domains within which culture can have effects, including communication behaviours, relationship to time and space, social and family organization, the meaning of work, health beliefs and practices, the meaning of food, sexuality and reproduction, religion and spirituality and death and dying.²² Nurses in New Zealand contend that their practice should make patients feel culturally safe and train nurses to attain this goal.²³ None of the models is supported by empirical data in health care practice.

Medical education provides physicians with some skills relevant to the achievement of cultural competence. Training in the patient-centred clinical method began in family medicine residency programs in the mid-1980s and is now offered in the majority of North American training programs.²⁴ This method stresses the importance of the patient's agenda and explanatory models (focused on the illness) in addition to the physician's agenda (focused on the disease).¹⁸ However, this method treats the patient as a member of a generic lay culture and the physician as a member of the Western biomedical culture.

We have identified only three published studies that have examined how primary care practitioners

actually address issues of cultural diversity in their practice. All used qualitative methodologies. Researchers in Canada who interviewed non-aboriginal physicians working with Aboriginal patients and communities found that experienced clinicians made changes in their communication style, were attentive to the community context of illness, and developed in-depth knowledge of cultural values and practices through participation in community events.¹⁰ In contrast, data collected in meetings of practice group clinicians in the UK revealed that organizational constraints involving lack of time and resources prevented clinicians from adapting their practice to cultural differences even when they were well aware of the issues.¹¹ Swedish GPs interviewed by Wachtler reported that they used the same approach with immigrant patients as with native-born Swedes. They used the patient-centred method, focussed on similarities between themselves and the patients and actively avoided cultural conflicts.¹²

Cohen-Émerique developed a method for teaching cultural competence and has used it with social workers and psychologists. The learners are asked to describe an incident in which they experienced a feeling of shock in an intercultural interaction.²⁵ Using this method, she collected 101 'critical incidents' and characterized the issues that caused culture shock.

Our review of the literature suggests that more empirical research is needed to identify strategies for effective intercultural clinical work in primary care. As a first step, we undertook to collect empirical data to identify and understand the range of strategies used by clinicians in medical encounters.

Method

Participants

We conducted purposive sampling of family physicians practicing in Montreal, Canada, selecting physicians to ensure maximum variation in the cultural diversity of their patients and the duration of their cross-cultural clinical experience. Of the 27 physicians contacted, 25 (93%) participated in the study. Two physicians did not describe any strategies. Therefore, we are reporting data from 23 physicians. We stopped recruitment when we had achieved saturation of the data.²⁶ There were 9 men and 14 women. Sixteen were born in Canada or the US, 21 graduated from a North American medical school and 22 perceived of themselves as Canadians and/or Quebecers. All participants except the seven Quebec-born individuals whose mother tongue was French also described themselves as members of at least one additional ethnocultural group among the following: Algerian, American, Armenian, Chilean, Czech, French, Irish, Italian, Jewish, Lithuanian, Persian-Indian and Ukrainian. They ranged in age from 31 to 55 years

(mean 44.4 years) and had been in practice from 5 to 30 years (mean 17.6 years). All physicians gave informed consent for the study.

Data collection

A medical anthropologist (SX) and a sociologist trained in qualitative health research (CL) collected data in 60- to 90-minute semi-structured interviews in English or French in physicians' offices. Interviews were tape recorded and transcribed.

Interviews elicited physician experiences and strategies of care during intercultural clinical encounters. Interviewers began by asking physicians to describe two clinical encounters involving a patient from a cultural background different from their own—one that the physician viewed as a difficult encounter and one that he viewed as an easy encounter. We asked physicians to use their own definitions of easy and difficult. We chose to ask physicians about specific difficult and easy encounters in order to identify rare events that tested the limits of physicians' interaction skills (difficult encounters) and common events in which physicians used skills that had proven effective over time (easy encounters). The method we used was very similar to that of Cohen-Émerique described above.²⁵ Participants described their clinical and interpersonal strategies in the two encounters. Interviewers then asked physicians whether an encounter would have been equally difficult or easy if it had been with a person of the opposite gender, a different age, level of education, culture, language fluency or for a different type of medical condition. Physicians often offered additional information about other encounters and more general comments about their intercultural clinical experiences and/or the communication strategies they used with all patients.

Data analysis

We conducted a thematic analysis of strategies for responding to cultural difference using a constructivist approach.^{26,27} Three of the authors [a family physician (ER) an anthropologist (SX), and a sociologist (CL)] reviewed the transcripts and identified categories that emerged from the data, for example strategies in easy encounters, strategies in difficult encounters, general strategies and intercultural strategies. The latter two categories contained spontaneous physician comments about the strategies they used in all clinical encounters and in intercultural encounters, respectively. We used a multidisciplinary inductive approach to create the categories. We came to a tentative consensus on a list of categories through discussion within the research team. The three analysts brought their three domains of expertise to the discussion and then separately coded the same three transcripts. The final list of categories is the product of subsequent group discussion to resolve discrepancies. The entire contents of six

transcripts were classified into categories by two researchers (ER and SX or ER and CL) and results compared. As they were nearly identical, only one person analysed each of the remaining transcripts. Major themes across categories were identified through extensive discussions within the group. We systematically looked for evidence of conflicting data before including any strategies in the final analysis. We assigned extracts of transcripts to themes using NuDIST. All three analysts concurred on the final themes reported below as well as the content coded within each theme.²⁸

We compared strategies of men to those of women, Canadian-born persons to immigrants, Francophones to Anglophones and physicians with a lot of cross-cultural experience to those with very little such experience but found no differences on the basis of membership in any of these four subgroups.

Findings

We classified physician strategies in intercultural encounters within three themes: (i) insistence on *patient adaptation* to local beliefs and behaviours; (ii) *physician adaptation* to what he or she assumed patients wanted; and (iii) *negotiation* of a mutually acceptable plan. Physicians addressed issues in three main areas: (i) diagnosis and treatment; (ii) interactions with the health care system; and (iii) third persons playing roles in the life of the patient and in the doctor-patient relationship that were unfamiliar to the doctor. In what follows we present the findings organized by strategy. Table 1 lists strategies in each problem area.

Patient adaptation

This strategy put the onus on the patient to adapt to the new situation in Canada. For example, MD 11 insisted on giving patients choices even if physicians in their country of origin were highly directive or authoritarian. Five physicians who insisted on an appointment system laid down their rules to patients. 'When you break these rules you are showing a lack of respect for my time and, therefore, for me' (MD 15).

MD 13 explained to adolescents that in Canada it is unacceptable for a parent to hit a child. Faced with women from patriarchal cultures, two physicians pressed women to exercise their individual rights (MD 16, 20):

These are young women who have no concept of their autonomy. They're brought up to think that what the man says is what they do. So I said 'you have a choice. In our culture it's possible for a woman to say no. You're really putting yourself at risk. Right now, you could be pregnant and you

TABLE 1 *Strategies used by GPs in intercultural clinical encounters*

Problem area	Strategies		
	Patient adaptation	Physician adaptation	Negotiation
Diagnosis and treatment	Require patient to accept conventional clinical approach; MD 11	Provide cultural group-centred care; MD 1–3, 5–14, 16–22, 25 Use interpreters; MD 6, 9 Overcome bias; MD 2 Modify diagnostic practices; MD 23, 11, 18	Referral for cultural match; MD 10 Provide patient-centred care; MD 3, 5, 9–12, 14, 18, 20 Modify treatment approach; MD 10, 11, 13, 19
Health care system	Present rules to patients; MD 2, 3, 12, 17 Admonish patients; MD 15	Understand patient's perspective; MD 7, 9, 10, 19, 22 Adapt practice routines; MD 5 Modify local health and social service systems; MD 3, 5, 8, 9, 10, 13, 15, 18, 22, 23 Explain rationale for physician actions; MD 15	Explain rationale for physician's actions; MD 15
Family and community	Explain local values; MD 16, 20 Invoke local regulations and laws; MD 13	Adapt to different male–female or parent–child relationships; MD 5, 6, 10, 11, 13, 16, 18–20, 23, 25 Use third person as mediator; MD 10, 15 Use non-confrontational tactics; MD 6, 10, 11, 13, 23, 25 Consult authorities; MD 23	Negotiate psychosocial role; MD 8

could have STDs.' (sexually transmitted diseases; MD 16)

Physician adaptation

As shown in Table 1: this is the most frequently used strategy. Some of the physicians recognized their own biases and worked to overcome them and treat patients as individuals rather than members of particular groups:

Whether we like it or not, we have prejudices. When I see either a Hasidic Jewish family or a veiled woman, I see the veil first. I see the little curls on the man's face. That's the first thing I see. It's the second level that you have to get to all the time. (MD 2)

Twenty physicians used stereotypes of the patient's ethnocultural origin (country, region, culture, religion) to generate hypotheses about the diagnosis and the treatment expectations. For example, because MD 11 believed that Haitian men have many sexual partners, she placed pelvic inflammatory disease high on her list of diagnostic possibilities of their partners. She explained her decision to test these women for sexually transmitted infections as follows:

I have said to Haitian women, 'you know how men are in your culture. You know that in Haiti polygamy is accepted' in order to open their eyes a little bit to their risk of STDs. (MD 13)

Sometimes physicians are aware of the limitations of their standard approach but have not found effective adaptations:

North African young men don't tolerate physical symptoms well. We try to explain to them that it is probably a minor dysfunction, but the symptom continues to worry them. Therefore, I usually do more investigations that don't clarify anything. (MD 14)

Two clinicians referred patients to specialists of the patient's own cultural group. However, this did not ensure a successful outcome. A patient complained to MD 10 that a specialist from her country of origin had treated her with disdain.

Several physicians were initially shocked by patients' insistence on rapid service (MD 7, 9, 10, 22). They became more accepting when they framed the behaviour as a necessary survival tactic in their homeland:

At first I thought 'My **God**, don't they **realise?**' But a lot of these new immigrants **have** to be pushy and aggressive to get here and settle in and to find out how things work. (MD 7)

When women from patriarchal cultures sought care, their husbands were often present. In these encounters, some physicians adapted their strategies:

You have to adapt, you have to go gradually. I'm much more gentle. It's a huge cultural social issue that I can only possibly make a little dent in. (MD 18)

MD 23 used clinic regulations as a pretext in order not to provide an unwanted treatment. Instead of saying 'I don't think your wife wants an IUD' she told a man she was not allowed to insert one at the walk-in clinic.

Physicians also described adapting to differences in parent-child relations (MD 6, 10, 11, 13, 23). MD 11 and 13, noting that immigrant adolescents were unlikely to discuss contraception with their parents, encouraged the adolescents to seek support from friends.

Asked to tell a man whether or not his daughter (age 16 years) was a virgin:

I asked myself, as a professional if I lie, but on the other hand telling the truth could cause a catastrophe. If the young girl thought that her father would beat her, and he had done so in the past. I called the department of youth protection and the professional Corporation [the licensing body for physicians]. The Corporation said I could lie to the father. (MD 23)

Negotiation

Many physicians emphasized their use of the same basic strategies of respectful listening, dialogue and negotiation with all patients and described this as patient-centred care (MD 3, 5, 9–12, 14, 20). The work involved establishment of a human connection, elicitation of the patient's explanatory model and expectations, acceptance, gradual education, negotiation and compromise to find common ground between one's own and the patient's beliefs and practices. These physicians all explicitly stated that they were using their basic core skills and listed the above elements and/or said that they used the patient-centred clinical method. Physicians focussed on the individual and not on the family or specific ethnocultural beliefs:

The technique is the same: respect for the patient. We have our own cultural and intellectual baggage. Sometimes we find it tiresome when someone is different from us. I listen to them. I negotiate. (MD 20)

I say 'formula is better until 9 months, but this milk will do if you absolutely have to. Will you let me help you prepare it in such a way that it would be okay for the baby?' Not to tell them that what their mothers have done is wrong. I try to use their cultural beliefs, but to instil the principles that I deem to be important and work out a compromise. (MD 19)

Sometimes members of the patient's social circle participated in the negotiation:

I learned from her family that she believed larger pills were more effective. I chose effective medications that were also big pills so that she would believe them to be beneficial and take them. (MD 15)

Discussion

We identified three broad strategies in physicians' intercultural clinical work: patient adaptation, physician adaptation and negotiation. None of the physicians described using any model of intercultural care in their interactions with patients. The majority of our physicians, like the Swedish physicians interviewed by Wachtler, spontaneously stated that they used a model to guide their care of all of their patients. They reported using the patient-centred model of care. Unlike Wachtler, we collected data based on specific clinical encounters. This method enabled us to establish that physicians varied in the degree to which they elicited the patient's perspective and/or modified their usual practice in response to the patient's views. Moreover, we were able to identify factors affecting the choice of strategies.

According to Bennett's model (see Table 2), intercultural sensitivity develops in stages.⁸ An individual begins with an ethnocentric denial of difference, progresses through negative stereotyping and then into the minimization of difference. One is then able to abandon the ethnocentric position moving to acceptance of differences. The next stage is adaptation to the differences. The person with full intercultural sensitivity has integrated others' differences into his or her own identity. Individual physicians employed multiple strategies representing several different stages. Only four physicians described strategies reflecting attitudes at only one of Bennett's stages. Nineteen of the physicians reported attitudes towards ethnocultural differences at more than one stage. Use of Bennett's Intercultural Development Inventory interprets this phenomenon by classifying an individual at one stage of the model, but identifies 'trailing issues' for which the individual is at a lower stage of development.²⁹

TABLE 2 *Bennett model of intercultural sensitivity*

Stages	Definition	Most advanced stage of study physicians (n)
Denial	Denial of difference	0
Defense	Defense against difference, for example negative stereotyping, assumption of cultural superiority	1
Minimization	Minimization of importance of difference. Emphasis on importance of similarities	2
Acceptance	Acceptance of differences in behaviour and values	5
Adaptation	Empathic shift during interaction, biculturalism	11
Integration	Integration of difference: application of ethnorelativism to one's own identity	6

The physicians we studied demonstrated different levels of intercultural sensitivity depending on the topic. Physicians demonstrated lower levels of intercultural sensitivity when dealing with issues about which they felt deeply. For example, the autonomy of women was especially important for eight physicians. On this issue, they were at Bennett's defense stage, taking a position of cultural superiority; for example explaining to women that they have individual rights and should not allow men to expose them to unwanted pregnancy or sexually transmitted disease. The rights accorded to children in Canada were sufficiently important to four physicians for them to adopt strategies at the defense stage in order to protect the rights of individual immigrant children. However, when faced with patients who used non-biomedical healing methods or interacted in culturally distinctive ways, all these same physicians described using strategies indicative of acceptance and/or adaptation stages. Cohen-Émerique has found that professionals react particularly strongly when faced with a client who has values that have only relatively recently been abandoned by members of the professional's culture. She argues that 'new' values such as the equality of men and women are seen as examples of progress and modernity and are relatively fragile. Therefore, a confrontation with individuals who hold 'older' values is particularly threatening.³⁰ One can hypothesize that these physicians felt less threatened by women who did not follow Canadian guides for the introduction of solid food to their children than by women who had unprotected intercourse with partners they believed to be promiscuous.

Methodology

Our objective was to identify and understand the whole range of strategies physicians used in intercultural encounters. Our use of semi-structured interviews with individuals with varied experience with the phenomenon of interest is likely to have elicited almost all the strategies used by family physicians in Montreal. Indeed, by the 23rd interview we had reached saturation (i.e. no new strategies were identified). Therefore, it is unlikely that one would identify other strategies by interviewing other Montreal family physicians. We did not aim to determine the frequency of use of the strategies identified. Thematic analysis of interview data using a constructivist approach permits one to generate explanations of phenomena. Our repertoire of strategies cannot be generalized to other physicians in other contexts.

As investigators, we bring our own identities, both personal and professional, to the work. The persons collecting data are a francophone québécois sociologist (CL) and an Anglophone Canadian anthropologist. CL, SX and ER who is an Anglophone Canadian family physician conducted the data analyses. Contributors to the theoretical framework are a Canadian

transcultural psychiatrist (LK) and a Swiss primary care physician (MDD).

Conclusion

The patient-centred model of care served many of our physicians well in their adaptations to a whole range of differences between themselves and their patients. The use of a patient-centred approach enabled physicians to take an appropriate personal and family history in intercultural encounters. However, several of our findings support an argument for the addition of specific cultural competence training to medical curricula. Clinicians' failure to describe a conceptual framework guiding their actions indicates that their actions were the result of unconscious tacit knowledge. For knowledge to be used, it must be made conscious and explicit.³¹ Second, intercultural work raises complex questions about individual autonomy that challenge the individualistic assumptions of the patient-centred model. Many of the difficulties physicians experienced related to instances in which men made decisions for women or parents made decisions for children without any evidence of consultation with the woman or child. Sometimes physicians accepted the family's pattern of decision-making, sometimes they attempted to elicit the patient's wishes without stating that there was a conflict of values and at other times the physician insisted on the importance of an autonomous decision by the patient. Whatever the strategy adopted, the physician remained uncomfortable. Knowledge of the dimensions of cultural variation would help physicians to understand more family-centred or even community-centred ways of experiencing life.³²

On the basis of our findings, we suggest that practicing physicians should attend continuing education training or read about the ways in which cultures differ. They should also work to develop awareness and understanding of their reactions to difference in their patients. Physician training should include the provision of an explicit conceptual framework for approaching patients from a different culture. Physicians should learn about the domains within which culture can have effects, including communication behaviours, relationship to time and space, social and family organization, the meaning of work, health beliefs and practices, the meaning of food, sexuality and reproduction, religion and spirituality and death and dying.²² This should also include explicit training in working with interpreters or culture brokers and on when to ask for more specialized consultation.³³

Second, we need to train clinicians to think in terms of family systems and larger social contexts that may vary significantly for patients from diverse backgrounds.³⁴ Finally, physicians need to learn to identify situations in which their own values are in particular

conflict with the values of a patient and/or members of her family or cultural community. In some of these situations, physicians may be bound by law to adhere to local cultural values encoded in laws or professional codes (e.g. child abuse, requests for female genital mutilation). In other situations, they will need to clarify their own values and to devote extra attention to negotiations with patients.

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